TESTIMONY OF RICHARD B. WEBER, M.D.
JOINT COMMITTEE ON HUMAN SERVICES
MARCH 2, 2010

Good morning Mr. Chairman and Committee members. My name is Richard Weber. I have been a practicing physician in Stamford, CT since 1987. I am a board certified internist and ophthalmologist and assistant clinical professor at Albert Einstein Medical School in New York. I was contacted a few weeks ago by the proponents of Raised Senate Bill No. 283 concerning the manner in which audits are conducted by the Department of Social Services ("DSS").

Evidently, through a Freedom of Information request, the bill's proponents discovered that the State of Connecticut settled claims that I had brought against the Department of Social Services and Office of the Chief States Attorney and multiple employees of these departments, including those in DSS's office of Quality Assurance and former DSS Commissioner Patricia Wilson-Coker. The bill's proponents asked me to share this experience with you. I do so with great interest and concern for other medical providers who encounter the DSS audit process.

My experience with DSS spans a period of more than ten (10) years. In the interest of brevity, I will inform you that I was the subject of an audit in 1999 at which time 8,000 extrapolated dollars were recouped by DSS for my use of a specific billing code. My office had consistently used that code based on instructions from DSS in 1995 and, as recently as September of 2006, my office manager again confirmed its use with provider relations by telephone.

As a result of the audit and my disappointment in the process and how I was treated, I contacted my State Representative Crystal Truglia. Representative Truglia, who asked me to prepare a letter outlining my experience which she forwarded to then DSS Commissioner Wilson-Coker.

Of great interest to this Committee should be the fact that on the very day that Commissioner Wilson-Coker responded to Rep. Truglia, the manager of the office of Quality Assurance, in retaliation for my letter to my representative and in violation of my right of free speech, had his staff initiate a criminal referral to the Medicaid Fraud Control Unit for investigation, prosecution and my eventual arrest.

During this investigation a Search Warrant was executed at my office with patients and staff present by armed Inspectors of the Medicaid Fraud Control Unit and Stamford Police Department, to seize about twenty five patient charts which could have just as easily have been obtained via other noninvasive and non-confrontational methods.

With the assistance of my attorney who is here with me today, Michael Kogut, and the law firm of Murtha Cullina, LLP, we vigorously fought the charges which I always believed were malicious and unfounded. Specifically, during a hearing for suppression and dismissal of the search and arrest warrants based upon violation of my right of free speech by contacting Rep. Truglia, heard by Judge Christine Keller in Hartford Superior Court, we prevailed as the state dismissed the charges after multiple days of testimony before Judge Keller.

Shortly thereafter, we sought permission to sue the State, Office of Chief States Attorney and Department of Social Services along with multiple state employees. The claim lingered and we were unable to receive any redress from the Claims Commission.

We therefore filed suit in federal court in December, 2006 against the same actors charging violation of my civil rights, malicious prosecution, wrongful arrest and overall wanton and reckless behavior by DSS and its employees during my entire audit process. After countless hours away from my practice and depositions and extensive discovery, the state finally settled in October, 2008.

Through the extensive discovery and FOIA request process we had a unique, though costly, look at the Department of Quality Assurance and its managers. I have reviewed an extensive number of audits, documents, computer printouts, provider complaints and correspondence.

My review of the DSS audit process revealed that often times it is arbitrary, capricious and very unfair to providers who generously serve a disadvantaged group of patients without the right to independent review or appeal from the draconian decisions of DSS. I should note that at the time I was audited, Medicaid represented less than two (2) percent of my overall reimbursement.

In light of my extensive experience with DSS and its Office of Quality Assurance, I think I have a somewhat unique viewpoint of Raised Bill No. 283. I applaud the bill's proponents and respectfully ask the Committee to give providers only what they are entitled to. A fair and objective process with the right to independent review and appeal.

I believe Section 2 of the original bill should limit review of claims to one (1) year.

In regard to Section 3, I would hope that the legislature would add to the list of items which cannot be extrapolated any billing dispute, legitimate grievance, or arbitrary ruling of the department, or any ruling which is not backed by an absolute rule, is capricious, not uniformly enforced, or the provider believed to be correct, etc.

As for Section 4, in light of the actions of the department and need to protect the providers, I would hope that the "or" just before "(B) documented....." would be changed to "and". This would protect the provider from at least the extrapolated damages resulting from DSS's arbitrary and inconsistent enforcement of certain rules for certain providers. I also believe the claims in the aggregate exceeding $150,000 on an annual basis should remain in subsection (C).

In regard to Section 6, again, in light of the prior conduct of this department, 30 days after the provider gives the required documentation should be sufficient to provide a preliminary report. Providers may have to report to their HMO's, insurers, licensing boards, hospitals etc, that they are under some type of investigation and limiting the time of this procedure would be beneficial to the provider as well as the state. We are aware of one instance where at least four years after the provider gave documentation, the department still had not produced a signed preliminary report and the audit remained open.

In regard to Section 7, again there is no time limit set for DSS to arrange the exit conference. This is to the detriment of the provider who would like for the audit to be closed.

As for Section 8, the provider should also have to agree to this later date, or the audit should be closed in favor of the provider.

In regard to Section 9, the appeal to a designee of the Commissioner is not a fair and independent review. In the past the appeal of an audit decision was directly to the Quality Assurance manager's supervisor. In addition, all sign offs for referral to the MFCU had to be approved by the same supervisor. After a FOIA request, the Department was unable to provide a single document to us where the supervisor overruled the manager's decision either to change an audit or overrule a referral for criminal investigation.

As far as I am concerned, this appeal process is ineffective. I would hope that the person or persons undertaking the appeal would not be a state employee but rather perhaps a panel of providers, physicians, nursing home personnel, or other independent knowledgeable individuals.

Lastly, the appeal to Superior Court provision contained in Section 10 is essential to maintain integrity in the process.

DSS has a huge budget yet there is no medical director over seeing this expenditure of funds or to act as an intermediary to this state agency.

Thank you all for your time and interest.